CORRECTED MINUTES *
(Approved by the Task Force)

HEALTH CARE TASK FORCE

August 26, 2009
Boise, Idaho

Members present were Senators: Co-chairman Dean Cameron, Joe Stegner, Patti Anne Lodge, Tim Corder, and John McGee; and Representatives: Co-chairman Gary Collins, Sharon Block, Fred Wood, and John Rusche. Absent and excused were Senator John Goedde, Senator Nicole LeFavour and Representative Elaine Smith. Legislative Services staff present were Paige Alan Parker, Amy Johnson and Charmi Arregui.

Others present were: Representative Sue Chew; Representative Phylis King; Bill Deal, Director, Department of Insurance; Russell Duke, Central District Health District; Steve Thomas, Idaho Association of Health Plans; Woody Richards and Julie Taylor, Blue Cross of Idaho; Joie McGarvin, America's Health Insurance Plans; Sara Stover and Wayne Hammon, Department of Financial Management; Kathie Garrett, Partners in Crisis; Benjamin Davenport and Risch Pisca, PLLC; Jayson Ronk, Idaho Association of Commerce & Industry; Dick Schultz, Paul Leary, Jane Smith, Mitch Scoggins, Dieuwke Spencer, and Robin Pewtress, Department of Health & Welfare; Lyn Darrington and Amy Holly, Business Psychology Associates, Inc.; Peg Munson, Sharon Fisher and Dede Shelton, American Association of Retired Persons (AARP); Skip Smyser and Martin Bilbao, Connolly Smyser; Colby Cameron, Sullivan & Rebeger; Denise Chuckovich, Idaho Primary Care Association (IPCA); Dr. Richard Rainey, Regence BlueShield of Idaho; Dr. Doug Dammrose, Blue Cross of Idaho; Dr. Robert Vestal, Idaho Health Care For All; Dr. Uwe Reischl, Boise State University; Laren Walker, High Risk Reinsurance Pool Administrator; Hyatt Erstad, Individual High Risk Reinsurance Pool Board; Julie Robinson, Family Medicine Residency of Idaho; Ross Borden, City of Boise; Mary Lou Kinney and Ernie Tablit, Healthy Tomorrows/Covering Kids; Krisi Packer, Boise State Radio; Bruce Krosch, Southwest District Health; Heidi Low, American Cancer Society Cancer Action Network; Susie Pouliot, Idaho Medical Association (IMA); Therese Bishop, Regence; Marilyn Sword, Developmental Disabilities Council; and Joy Johnson Wilson, Health Policy Director, National Conference of State Legislatures (NCSL) participated via conference call from Washington, D.C.

Co-chairman **Representative Gary Collins** called the meeting to order at 9:38 a.m.

Representative Fred Wood moved that the minutes from July 16, 2009, be approved with one additional name (Larry Benton) to be added to the attendees and that one correction be made (Ann Holly, Bonneville Power Administration) be changed to "Amy Holly, Business Psychology Associates" and the motion was seconded by Senator Lodge; the motion passed unanimously by voice vote.

***Corrections: (1) Page 1, paragraph 3, "Senator" Gary Collins changed to "Representative" Gary Collins and (2) Page 3, paragraph 1, line 2, "$105,000" changed to "$205,000"**

The first presenter was **Jane Smith**, Administrator, Division of Health, Department of Health and Welfare, who distributed a binder entitled "SCR 112, Adult Cystic Fibrosis, August 26, 2009," available in the Legislative Services Office. **Ms. Smith's** PowerPoint presentation may be accessed at www.legislature.idaho.gov/sessioninfo/2009/interim/healthcare.htm.

Ms. Smith pointed out that Senate Concurrent Resolution 112 requested that the Department of Health and Welfare (DHW) focus on four goals: (1) Individual Responsibility (2) Uniform Financial Eligibility (3) High Risk Insurance Pool and (4) Aligning Scope of Services. The adult Cystic Fibrosis (CF) Program proposes to separate adult from children's services; "adult" to be defined as 18 years of age and older (versus current statute's 21 years of age); and a new chapter of rules would be required.

Ms. Smith said that an overarching theme of SCR112 is individual responsibility and that theme has been applied throughout the Department's proposal. Under that proposal, the documentation of income (IRS Form 1040, 1040A, or 1040EZ) will be required to determine financial eligibility. With regard to financial eligibility, DHW recommends that the adult CF Program cap eligibility at 200% of the federal poverty level (FPL), which is consistent with the majority of adult Department programs. **Ms. Smith** defined income with four options, emphasizing there could be many others:

Option #1: "Income" defined as **Gross Income, line 22, IRS Form 1040** of the participant's federal tax return.
Option #2: "Income" defined as **Adjusted Gross Income, line 37, IRS Form 1040** of the participant's federal tax return.
Option #3: "Income" defined as **Gross Income, minus line 4 (Medical/Dental Expenses), IRS Form 1040, Schedule A** of the participant's federal tax return.
Option #4: "Income" defined as **Taxable Income, line 43, IRS Form 1040** of the participant's federal tax return.

Ms. Smith opined that the High Risk Insurance Pool is not an effective cost-control option for the CF Program since subsequent years provide a 50/50 coinsurance for pharmaceuticals resulting in little or no cost savings and there is a one year no-coverage clause for pre-existing conditions and thus the first year would be high cost with no savings to the program. The High Risk Insurance Pool would also provide a benefit and level of coverage not available through other adult programs.

With regard to aligning scope of services, **Ms. Smith** said that under the Department's proposal there would be no co-pays. With a proposed financial eligibility cap at 200% of the FPL, continuing to require co-pays would be inconsistent with other adult programs. The Department's proposal would not change other aspects: e.g., residency requirements and insurance status keeps the program aligned with other adult programs.

Ms. Smith gave fiscal information as follows:

- State Fiscal Year (SFY) 2010 Adult CF appropriation is $205,000, the same as for SFY 2009;
- The Adult CF Program's estimated receipts of $7,200 went back to the program;
- For SFY 2009, the Adult Cystic Fibrosis Expenditures Grand Total equaled $212,144, with 69.2% going to patient medical claim, 23.5% going to the CF clinic and 7.3% going to the CF physician.

Ms. Smith said that in FY 2009 there were 3,115 total CF claims of which 1,469 were Adult (47.2%). The projected SFY 2011 budget is $322,500, including the $7,200 estimated receipts, broken down as follows:

- Administrative Costs = $85,800
- Clinic & Physician Costs = $59,700
- Medical Claims = $177,000

The annual cost are expected to increase each year due to increased medical costs, new equipment and pharmaceuticals, and increasing patient numbers. Between now and the end of SFY 2011, 9 Children Special Health Program (CSHP) CF patients will turn 18 years of age. Five more CSHP CF patients will turn 18 years of age during SFY 2012.

Ms. Smith stated that the next steps will be:

- 2010 Legislative Session - Propose budget request decision unit: SFY 2010 funding was one-time only. Additional appropriation will be needed to continue program.
- 2010 Legislative Session - Section 56-1019, Idaho Code, needs to be updated, including changing Adult CF Program coverage from 21 to 18 years of age.
- Spring 2010 - Draft proposed rules consistent with legislation adopted during the 2009 session, including a new proposed IDAPA chapter specific to adult CF and a revised IDAPA 16.02.26, Children's Special Health Program, to remove references to adults with CF.
- Summer 2010 - Hold regional meetings on the proposed draft rules in order to provide information and gather public input.
- 2011 Legislative Session - Present the pending rules to the Legislature to become effective upon Sine Die.

Representative Marriott asked about the high administrative cost of $85,000, wondering if it wouldn't be better to do away with administrative costs and give cash. **Ms. Smith** explained that personnel costs are included in that figure and that she didn't believe giving the cash away would survive an audit.

Representative Rusche asked whether the Child CF Program was funded through the federal government. **Ms. Smith** responded that it was 100% federal funds. **Representative Rusche** what the federal age cutoff was and whether the Idaho program should be consistent. **Ms. Smith** answered the Department is looking at consistency, adding that all other programs stop at age 18,

and that administrative costs for clinics are borne by federal dollars. **Representative Rusche** clarified that the block grant allows coverage up to age 21 and asked if the grant funds could be used for other purposes if the Idaho age cutoff was at 18 years. **Ms. Smith** said that was true.

Representative Rusche commented that disabled adults can obtain Medicaid coverage on a sliding scale that goes up to 500% of FPL and asked why the adults with other diseases can't be considered for Medicaid. **Mr. Dick Schultz**, Deputy Director, Health Services, Medicaid, said this is certainly an option, but trying to carve out for this limited number of individuals would be a difficult challenge. **Representative Rusche** asked whether the Department could investigate the possibility of including other disabling conditions within the Medicaid buy-in. **Mr. Schultz** said he wasn't sure that CF, in and of itself, is a diagnosis that confers disability, but agreed that factors associated with CF might put them in that category.

Representative Rusche asked what might happen to counties if dollars run out and they have significant expenses for an individual who may make more than $25,000 annually, at about 200% of FPL. **Ms. Smith** said that with their 55 CF patients, only 9 do not have insurance. **Mr. Schultz** said it would be challenging to determine which individuals could be eligible under the county indigent fund. He said that currently the CF program is not costing a great deal and has a cap of $18,000. If some individual exceed that cap, he does not know what the counties would do regarding indigent status.

Representative Wood asked about what comprised the term "patient medical claims" which comprise 69.2% of FY 2009 Adult CF expenditures totaling $146,889. **Ms. Smith** answered that was for pharmaceuticals, prescriptions, and diagnostics. **Representative Wood** asked about what the federal government use to determine FPL. **Ms. Smith** said that figure is gross income. **Representative Wood** said he thought that Idaho should try to align income and eligibility with what the federal government uses to determine FPL.

Senator Cameron asked what the potential cost savings of each adjustment proposed by the Department and the number of people affected by each of these changes. **Ms. Smith** referred to Tab 6 of the binder, entitled "Per Patient Medical-claim Costs from FY 09 and Gross Income." She stated approximately $7,580 would be saved by limiting benefits to those at or below 200% FPL, but that the proposed changes are not cost-saving measures. Rather, the proposed changes provide better alignment with current programs. **Senator Cameron** asked how many individuals would be affected and how much savings would be generated by reducing the Child CF Program age from 21 to 18 years. **Ms. Smith** introduced **Mitch Scoggins,** Manager, Children's Special Health Program, who stated that the there should not be a financial impact since the Department has already been cutting children from the Child CF Program at 18 years but allowing them to receive Adult CF Program benefits.
Senator Cameron asked whether the Department was requiring those individuals with private insurance to have that insurance be primary with the Idaho program providing the excess. **Ms. Smith** stated that this was the practice. **Senator Cameron** asked if the Department was encouraging those individuals without insurance to obtain coverage, perhaps through the High Risk Pool. **Ms. Smith** stated that many in the CF program do not have the ability to obtain insurance, since the High Risk Pool premiums are high, especially for the first year.

Senator Cameron wondered about the possibility of Idaho becoming a Mecca for people with CF. **Ms. Smith** answered that she personally believes there will be some people coming to Idaho since states around us do not cover CF programs. However, SCR 112 asked the Department to prepare a report on the four issues identified therein. She believes that patients will increase and costs, already projected to be at $322,500 for FY 2011 budget, will continue to rise. **Senator Cameron** asked what the cost will be if the co-pay is eliminated. **Ms. Smith** said the Department has not been very successful at collecting that co-payment, so that would be a major cost. Dropping the FPL to 200% from 300% would make the lost of the co-pay cost-neutral.

Representative Bilbao said he has received numerous letters from extremely agitated people about adult CF care and asked if rules are being proposed to cut services, adding that people are extremely agitated about that possibility. **Ms. Smith** answered that proposed rules will be taken to the public for comments, adding that there is already an $18,000 cap on services and the proposed changes will not effect services greatly.

Senator Lodge commented that at least one of the pharmaceuticals used to treat CF used to be mixed by pharmacists in Idaho with ingredient cost of about $25 but that the same prescription is now being sold by a pharmaceutical company for about $2,300. She asked if there was anything the Legislature could do to limit that drastically inflated cost. She said several legislators have written letters to the pharmaceutical company who has the patent on this drug, without receiving a responses. **Ms. Smith** said that she has not received any response. **Senator Lodge** state that she personally disturbed from not getting cooperation from the pharmaceutical companies. **Mr. Schultz** said that if physicians wrote a prescription that identifies the ingredients, rather than identifying a drug name, then the pharmacist could mix it at a much lower cost, but the challenge lies in getting the physician to undertake that variation from the patented medication. The lack of volume for the CF population makes it difficult to qualify for price breaks like those received in the Medicaid program.

Mr. Schultz said the Department is presenting to the Health Care Task Force with the report requested in Concurrent Resolution 112. The Department is now seeking guidance as to where this task force would like the Department to do. Last year, the Department proposed legislation that would eliminate the state's responsibility to cover CF. That legislation failed. So now, the Department is open to suggestions, especially with regard to consistency, so that the rules don't say one thing while the statues say another. Specifically, he asked for guidance on whether 200% of FPL be adopted, whether gross income, adjusted gross income or some other income measure

be used, and what the age for the children's program should be. He said there is a "placeholder" request in the budget for $322,500 until further guidance is received.

Representative Collins invited public comment. No audience attendees chose to speak.

Ms. Smith updated the task force on the immunization program. She reminded the task force that she had presented at its July 16, 2009, when she informed the members on the consequences of Idaho going from universal select status to Vaccine for Children Program (VFC) only status. Following that meeting, the task force wrote a letter to the Governor requesting temporary immunization funding until the Legislature could find an alternative funding source. The

Governor responded positively on August 4, 2008. On that date notice was sent to all providers that there would be a continuation of the universal select status and the website was updated, answering potential questions. On August 6, 2009, $2.1 million was received by the Department and the program is currently placing orders for providers. She pointed out that some providers purchased vaccines during that gap. The Department is updating its spending plan with the Center for Disease Control. The phone inquiries have diminished regarding immunizations. She said the number of providers currently enrolled in the immunization program, is about 325, which is excellent. More providers are interested in joining.

Representative Marriott asked if there was a bigger cost for immunizations delivered by private healthcare providers. **Ms. Smith** said that vaccines are provided free to the provider. The physician may charge an administrative costs, which may be waived if there is an inability to pay. **Representative Marriott** said that he had received communications from providers who stepped up and purchased vaccines initially and asked if they will be able to recoup their expenditures from insurance. **Ms. Smith** said her understanding was that most insurance companies have agreed to reimburse providers for vaccine until September 1, 2009, giving those providers the opportunity to use up privately purchased vaccines.

Representative Rusche pointed out that while there are some insurance plans covering vaccines, most apply to deductibles, and that citizens are having to pay retail instead of the wholesale price, for privately purchased vaccines.

Senator Cameron thanked the task force for stepping up on the immunization issue and thanked the Governor for listening to the task force's request to use $2.1 million of the Governor's discretionary funds to cover immunizations through January 31, 2010. Now, the task force needs to come up with a more permanent funding solution for immunizations, and, with the co-chair's permission, he suggested that the task force form a subcommittee to work on this issue with the private sector. **Representative Collins** volunteered to serve on the Subcommittee on Immunizations , as did **Senator Cameron, Senator Lodge, Senator McGee, Representative Bilbao, and Representative Rusche.**

Senator Cameron referred back to the CF program, acknowledging that the Department is seeking input, and suggested that, in the future, concerned individuals be invited to come before the task force to state their case. He commented that CF issues may be more about policy than financial, and he encouraged the Health and Welfare Committee Co-chairs to be involved in that discussion, as well as other task force members.

Representative Rusche said that in July a vaccine plan was discussed about trying to improve immunization rates through outreach and promotion and including the planning and funding components; he asked if any progress had been made. **Ms. Smith** responded that the Department's Director has put together a physician's panel on this matter. The panel's suggestions include:

- Redesigning Quality Assurance Review visits to meet provider and program needs better and focus on sharing of best practices.
- Conducting Shot Smarts and an Immunization Summit (Spring 2010).

- Identifying options for providing general public education.
- Continuing to work to mobile the Immunization Coalition.
- Piloting IRIS reminder/recall with a large medical provider in northern Idaho. If successful, reminder/recall from IRIS will be expanded.

Ms. Susie Pouliot, Idaho Medical Association (IMA), addressed the task force on the immunization program from physicians' perspectives. She said that in late June, 2009, the IMA tried to institute a state co-op to continue the universal immunization program and when that effort collapsed, the IMA stepped up and formed a business partnership with a company that allowed all Idaho physicians to purchase vaccines at a discounted rate. Some Idaho physicians purchased stocks of vaccine through this program and made the necessary changes and trained staff to ensure that the privately purchased vaccine was handled differently than the VFC vaccine. Some physicians could not afford to purchase vaccine through this program and thus opted out.

Ms. Pouliot expressed her gratitude to the task force and to the Governor for stepping up and providing funding for the immunization program through January 31, 2010. After the Governor announced his decision on August 4, 2009, the IMA was flooded with phone calls from physicians who had made significant investments in purchasing private stocks of vaccine at a cost of $5,000 to $30,000, wondering what to do since patients will once again be provided with state purchased vaccine. Regence BlueShield and Blue Cross of Idaho, stepped up and agreed to reimburse physicians for their privately purchased vaccine stock when they immunize insured children; however, not all children are covered by these two carriers. She said that Blue Cross has a deadline of September 30, 2009, when it will stop reimbursing physicians for privately purchased vaccine. Regence BlueShield does not have any such deadline, but depending on the patient's policy terms, there could be dollar or age limits.

Ms. Pouliot said that IMA did take a very quick survey of its members and based upon 40 responses, 30 practices did participate in the universal program and 24 practices continued to participate by buying private stocks of vaccine after July 1, 2009. She said the IMA asked practices if they did expect to restock their supply of privately purchased vaccine by September 30, 2009, and 25 responded; 14 said "no" and 11 said "yes." Most practices expect to have those private stocks used up around November or December, 2009. She commented that it is very unfortunate that physicians who did step up are the very physicians who stand to lose out in this situation. Of course, those physicians will try to get their privately purchased vaccine used and will hope to be reimbursed by participating insurance companies.

Ms. Pouliot did emphasize that the January 31, 2010, deadline is nearing and stressed the complicated procedures physicians must make in their offices to accommodate any changes. She thanked **Senator Cameron** for suggesting that a subcommittee be formed to examine this issue. The chaos experienced in June and July caused a great deal of confusion, concern and problems for patients, providers and the Department, as well as policy makers. She expressed concern on behalf of the IMA that if there is not a permanent solution in place, well in advance of January 31, 2010, the state will face the same dilemma all over again. Her concern is that physicians who stepped up the first time and made that investment in vaccines, may not be as willing to do it again. **Ms. Pouliot** said the IMA is willing to participate and bring information

from the physicians' perspective to the table. Not only does the IMA advocate for physicians, part of it's mission is to advocate for public health.

Senator Stegner expressed his belief that this task force ought to recognize what a mess the state of Idaho made of this immunization situation by taking one action and asking providers to step up to the plate and respond, and then reversing itself in a relatively short period of time, causing significant confusion and economic loss for physicians who were trying to do the right thing. He said that the insurance companies have stepped up to cover some costs, basically reducing or eliminating deductibility, but so far nothing has been done by the state to help correct this in terms of reimbursing those physicians who stepped forward. In contrast, physicians who chose not to take that risk came out fine. **Senator Stegner** believes that the state has some responsibility in this matter, and he asked if the new Immunizations Subcommittee could also review this particular issue to see if some recommendation might be made with regard to the state sharing in some of that cost so that the physicians who stepped up were not left holding vaccine they cannot use or for which there is no demand. Representative Collins agreed that this could be part of the subcommittee's mission.

Senator McGee asked what the shelf life on these vaccines is. **Dr. Richard Rainey**, Idaho Medical Director, Regence BlueShield of Idaho, answered that he believed the shelf life to be about 6-9 months, but there could be vaccine lots that might expire sooner. **Representative Rusche** said that shelf life on vaccines depends upon the vaccine type. **Representative Rusche** reminded that when the Subcommittee is reviewing possible reimbursement of physicians who purchased vaccine on the private market, the fact that there is a markup and profit on the administering of such vaccine, although there are overhead cost associated with purchasing, storing and administering the vaccine. Also, the fact that some billings will be uncollectible and some vaccine will not be used within its self life, resulting in loss, must also be considered.

Representative Bilbao asked what the approximate dollar amount might be for reimbursement. **Ms. Pouliot** believed that IMA could gather that information based on physicians who used the companies with whom the IMA partnered and pointed out that physicians must purchase vaccines at a greater cost than what the state pays for under the universal vaccine program.

Mr. Russell Duke, Director, Central District Health Department, spoke on the Idaho immunization program. He also thanked this task force and the Governor for extending the universal status. He said the local public health districts strongly encourage the Idaho Legislature to continue funding childhood immunizations long term. **Mr. Duke** also reiterated that making this change after providers and the public health districts, privately purchased vaccine may create financial issues. He said that all unused private vaccine remaining after September 30, 2009, will be at the expense of the health care provider with no means for reimbursement. He pointed out that now that vaccines are free, parents are going back to private sector providers, after public health districts geared up to serve those children, leaving a sizable inventory on hand.

Mr. Duke shared that strategies to improve immunization rates are also very important to local public health districts. Two resolutions were passed at public health districts board meeting in May, recommending policy changes to improve immunization rates in Idaho. One resolution recommended that the Idaho Administrative Code regarding child care and schools be make

consistent with the immunization recommendations adopted by the Centers for Disease Control. The other requested that Idaho take steps to reduce the ability to opt-out of the childhood immunization requirements for school age children. (These IAD Resolutions 09-02 and 09-03 are available in the Legislative Services Office.) In discussing these resolutions, **Mr. Duke** noted that one national survey ranked Idaho last with regard to chicken pox immunization. All vaccines recommended for children through 6 years of age are already covered under universal status in Idaho and funded partially through State General Fund. Updating school entry and child care laws are proven methods to increase childhood immunization rates. Mr. Duke also noted that recent data shows that Idaho children on Medicaid, who are not participating in the Women, Infants and Children Program, have the lowest immunization rates in the state. Considering the number of children publicly insured in Idaho, policy changes in the Children's Health Insurance Program designed to ensure that children insured with public funds are immunized could have a substantial impact on Idaho's childhood immunization rates. **Mr. Duke** pointed out that there are no magic ways to improve immunization rates, but expressed hope that progress will be made through policy changes, as well as group strategies through the Department of Health and Welfare.
Representative Collins asked **Mr. Duke** what his feelings were about recouping expenses for public health districts. **Mr. Duke** replied that the health districts will definitely have vaccine purchased through the Minnesota pool that will not be used by September 30th and for which the health district will not be reimbursed. He added that 30% of the clients served by the health districts are privately insured. He was not sure of the exact dollar amount of the vaccine for which reimbursement will not be forthcoming.

Dr. Doug Dammrose, M.D., Senior Vice President, Chief Medical Office, Blue Cross of Idaho, gave the task force an update on the Blue Cross' response to Senate Bill 1107 (2009) on coverage for amino acid based elemental formulas for certain conditions. **Dr. Dammrose** passed out a packet of information, available in the Legislative Services Office. **Dr. Dammrose** said that currently most contracts have "formula" as a specific exclusion. Historically, Blue Cross has covered this under the Individual Benefits Section of the contract. This has allowed expansion of the benefit in a way that provides a more cost-effective treatment for the condition in question. Concerns have been raised that children with gastrointestinal conditions for which formula may be indicated were not receiving this care. Legislation was introduced to mandate coverage for amino acid based nutritional supplies for children under the age of 18, and opposition was also expressed. **Dr. Dammrose** said that he and and **Dr. Richard Rainey** of Regence Blue Shield of Idaho met with **Senator Steve Bair**, the bill's sponsor, to discuss issues related to mandating this benefit and the potential difficulties associated with such a mandate. The concern was the risk that many types of formulae and nutritional supplements would be requested, even though there is not a true medical indication. There was agreement that a plan to address all of Senator Bair's concerns would be implemented. **Dr. Dammrose** shared with the task force members the Blue Cross plan and gave a summary of interventions.

Dr. Richard Rainey Idaho Medical Director, Regence BlueShield of Idaho, gave the Regence update on Senate Bill 1007 (2009). He said that background information for Regence was the same as presented by **Dr. Dammrose**, but added that Regence does cover formula required by

rule and consistent with requirements. The general practice of Regence is consistent with its contracts and state regulations; however, Regence has reviewed requests for formula treating severe food intolerance in young children. He noted that Regence expects that for less severe conditions, members will work under the direction of their physicians to try conservative treatments. He said that Regence had made several approvals of coverage of formula for severe conditions based on review of cases in past years. The rationale for approval of severe disease is as an alternative benefit, benefits for services not otherwise covered, but Regence may approve coverage after evaluation by nurse case managers and review of medical directors. Alternative benefits may be covered and will result in overall reduced covered costs and improved quality of care. Alternative benefits are approved on a case-specific basis. **Dr. Rainey** said the steps for approval are as follows:

1. Request for coverage after multiple discussions with child's physician;
2. After accurate review, Regence agrees to cover requested formula for a period of 21 months based on clinical information submitted.
3. Although formula is not a contractual benefit for a member, based on physician discussions, covering formula reduced overall medical costs.
4. If this member still requires special formula after the approved 21 months of coverage, Regence will consider an extension of coverage at that time, based on clinical information at that time.
5. In addition to approvals mentioned, Regence identified the appeals and denials over the last 4 ½ years and, in reviewing claims histories of members who had appealed, the

   claims review did not identify any young children with active, severe food conditions, other than children who had already been approved.
6. Regence will continue to consider requests for formula treating severe food intolerance in young children as an alternative benefit and staff has been alerted to this issue

Representative Block thanked the doctors for their presentations and for providing answers to questions from constituents. She asked if this problem is one specific to young children and, if they outgrow this condition, at what age. **Dr. Rainey** answered that there are a number of conditions that are never outgrown, some being lifelong and requiring special foods. He said that many other conditions are outgrown by school age.

Dr. Robert Vestal, M.D., Co-chair, Idaho Health Care for All, introduced **Dr. Uwe Reischl** of Boise State University to the task force. He began by noting that there is a serious problem with regard to health care and the uninsured in this country and in the state of Idaho. He said that several years ago he became aware of **Dr. Reischl** who has been working with a concept that **Dr. Vestal** believes will be of interest to this task force and to the Legislature.

Dr. Reischl, M.D., Ph.D., Professor of Health Sciences, Boise State University, presented a Power Point to the task force entitled "Health Insurance Public Utility Corporation - An Alternative Approach to Health Insurance in Idaho" which is available in the Legislative Services Office and at www.legislature.idaho.gov/sessioninfo/2009/interim/healthcare.htm. **Dr. Reischl** is a public health physician with a focus on public health policy and occupational health, with 23 years of university research, teaching and administration experience.

Dr. Reischl gave a summary of the concept that he believes might offer an alternative solution beneficial to Idaho and applicable to many situations with regard to health coverage and costs. His concept is a public utility model to health insurance, which has the desirable features of being: not a "foreign" model; Idaho specific; for-profit business; transparent; fair and equitable practices; and opportunity for public input. His concept solution would be a privately operated, for-profit Health Insurance Public Utility Corporation. The features of a Public Utility Corporation (PUC) would be (1) Privileges such as geographic exclusivity, large customer base, guaranteed profitability, and privately delivered. (2) Requirements would be: efficiency, non-discriminatory, business transparency and regulated by a health insurance public utility commission.

Senator Stegner inquired if all Idaho citizens would be required to participate in the Health Insurance Public Utility Corporation. **Dr. Reischl** responded that it would be desirable, but not mandatory. **Senator Stegner** said this is also a crucial element in the national health care debate - if someone chose *not* to participate, what would be the medical safety net the state would provide. **Dr. Reischl** answered that a public utility company with geographic exclusivity would drop insurance premiums about 35 percent. Lower premiums would then allow a greater proportion of the population to buy health insurance, causing uninsured to get insurance. There would be no competition allowed. The individual would have the choice of purchasing health insurance thru PUC, or not purchase. **Dr. Reischl** said this model concept would have to go through a political review process. He believes that everyone who could afford coverage would choose to do so. For very low-income families, it would be cheaper for Medicaid to pay the insurance premium for the Medicaid recipient than to pay providers directly.

Senator Stegner stated that he has been thing about a statewide pool for some time. However, the self-regulated plans by large corporations are governed by federal law and the state of Idaho cannot regulate those. He how **Dr. Reischl** would overcome that hurdle. **Dr. Reischl** responded: "This is why I would need your input."

Representative Marriott asked why a PUC could not be used to regulate the existing private insurance companies. **Dr. Reischl** said the issue is that competition in the insurance market is detrimental to the efficiency of each of the insurance companies because of a limited or reduced risk pool. He said that every insurance program requires a majority of subscribers to remain healthy in order to redistribute services to those in need. If multiple insurance companies competed for limited risk pool, to stay in business these companies would have to either (1) reduce covered services or (2) increase premiums. This would *not* be in the best interest of the greater public.

Representative Wood opined that financing of health care cannot be fixed until *delivery* of health care is fixed or reformed in the United States. He asked if **Dr. Reischl** had thought about reforming the delivery of health care before reforming the financing of it. **Dr. Reischl** responded that reforming financing of health care is the first step in influencing the delivery of health care. According to **Dr. Reischl**, delivery of our current health care is being dictated by the way the services are being reimbursed, Health care delivery in the United States is very much based on the insurance reimbursement policies that have emerged over the last 40-50 years. The financing

component of the PUC model allows a reimbursement to be put into motion a that encourages evidence-based, best practices-based medicine and would allow the health care delivery component to respond to priorities the public deems appropriate. He asked rhetorically, Why is primary health care in Idaho not focused on or emphasized more than it currently is; he says the reason is that primary health care does not pay? He said it is very difficult for physicians to repay student loans in a reasonable time frame unless physicians specialize. The financing mechanism of our health care system benefits and encourages specialization of physicians. Thus, the first step is to deal with health insurance financing.

Representative Wood agreed that some areas of financing need to be reformed; however, he did not feel that the system could be reformed in the manner in which **Dr. Reischl** proposed because any added benefit is simply going to increase the cost of health care and because the elimination of the entire private sector of the economy is probably not something that would be received.

Representative Rusche commented that number of people insured by multi-state employers, Medicaid, Medicare and the federal government reduce the pool of individuals available to be insured through the PUC model to about half the population of the state and asked how this would affect the PUC model. **Dr. Reischl** believes that a health insurance program that offers premiums significantly lower than other health insurance carriers would encourage many national corporations who have employees in Idaho to cover them through state PUC health insurance. Since the model would focus on the individual, **Dr. Reischl** said companies would not be required to pay for their employee's health insurance. Instead, each employee, resident and citizen would have the opportunity to purchase coverage, with perhaps the employer offering the employees the option of an increase in pay.

Senator Cameron asked for clarification on how provider would be reimbursed and at what rate under **Dr. Reischl's** PUC model. **Dr. Reischl** answered that his model reduces the impact on health care providers due to lower cost of administration by eliminating the paperwork associated with multiple carriers. **Dr. Reischl** envisioned that PUC would reimburse the health care providers at a higher rate, some significantly higher, in order to encourage health preventive medicine. Certain services would reimburse at a lower rate pursuant to best practices. Currently, insurance plans are short-term and have no incentive for prevention. However, with a PUC that is going to remain in business long-term, prevention will be everything since developing a pool of clients who are health is the foundation of fiscally sound health care program.

Senator Cameron said he would be very interested in seeing actuarial evidence supporting the claims being made by **Dr. Reischl**, especially with regard to the suggestion of 35% cost reduction and the ability to also reimburse at a higher rate than is being done currently. **Senator Cameron** stated that many companies today are practicing evidence-based medicine and are trying to do some of the things proposed in the model, including preventive measures. **Senator Cameron** said that mandatory enrollment could cause a lack of support. **Dr. Reischl** answered that coming up with actual projections is a nationwide problem because of the lack of transparency of insurance companies, which consider information to be proprietary. He said that by having a large risk pool and allowing citizens to enter that pool without pre-conditions, long-

term costs can be reduced dramatically.

Senator Lodge stated that health care, to her, is a very personal experience. She then asked if **Dr. Reischl** had anything in his model about tort reform. **Dr. Reischl** said that the fundamental question to be answered is whether access to health care is a privilege or a right. The answer, he believes, is that health care is always a right, just like the access to education. Tort reform and malpractice cases would, he believes, become minuscule issues compared to what they are now under his model concept. If an individual has his arm cut off, universal health insurance would provide coverage for rehabilitation, including the prosthesis and training. The reason lawsuits have become such a burden to the health care system is that citizens who are injured through no fault of their own have no way of surviving except to depend upon the legal system to recover costs to allow them to live a decent life. In other countries where patients survive catastrophic diseases or injuries, patients don't have to sue, since their insurance company pays. **Dr Reischl** believes that through health care reform, there would be less incentive by an injured party to sue because the individual would be covered by health insurance.

Joy Johnson Wilson, Health Policy Director, National Conference of State Legislatures (NCSL) presented her PowerPoint presentation entitled "Federal Health Reform Update" and participated in this meeting via conference call from Washington, D.C.

Ms. Wilson gave a brief history of past efforts at health care reform, including the adoption of Medicare in 1988, which included a premium tax for a prescription drug benefit that was repealed in 1989, and the 1993 "Hillary Care" proposal that had a managed care component and that was opposed by both large and small businesses. The difference with prior efforts and the current health are reform effort include:

1. Both large and small businesses believe that there is an economic imperative to do something. Business is not longer opposed to managed care since most have insurance programs with managed care components.
2. The current health care reform effort is focused on a number of key issues:
    a. Increasing coverage
    b. Controlling cost
    c. Emphasizing prevention
    d. Improving health care infrastructure
    e. Improving volunteer care
3. Address the uninsured, including those who cannot afford an employer plan; those working for employers without a plan; the uninsurable; the "invincibles, " the early retirees with preexisting conditions; the philosophically opposed; and other "gap" people.
4. Not trying to build from the bottom up but is trying to renovate and update health care, she may be more difficult.
5. Getting the most bang for the buck by addressing primary/preventative care; managing and coordinating high risks individuals; providing better coordination between Medicare and Medicaid; and improving community based care.

Ms. Wilson's presentation covered: Hill players, stakeholders, the budget, Congressional mathematics, what is reconciliation, what is the "Byrd Rule," general consensus issues, goals, the

game plan in brief, overview - insurance reforms, individual responsibility, premium subsidies, cost-sharing credits, penalty, employer responsibility, small employers, insurance reforms, essential benefits, Medicaid reform, controlling costs, financing reform, insurance reforms, Medicaid reform, overarching reforms, funding issues, and a winning game plan. This presentation is available at:
www.legislature.idaho.gov/sessioninfo/2009/interim/healthcare0826_wilson_presentation.pdf

Representative Rusche inquired about the time line with regard to national health care reform as it would affect states. **Ms. Wilson** answered that if legislation was passed in December, some Medicaid components would become effective about six months later. She said that for larger programs, the eligibility categories would become effective in 2013.

Senator Stegner asked the odds of some health care reform proposal passing. **Ms. Wilson** believe it to have a 50/50 chance. More will be known when the Finance Bill is revealed and what kind of reception it receives; if that bill excites people, she believes passage to be possible, pointing out there is great pressure on the Chair of the Finance Committee. **Senator Stegner** asked how **Senator Edward Kennedy's** death might affect passage of health care reform. **Ms. Wilson** said that his death may improve possibilities of passage of legislation since he was so passionate about this issue, and was so popular on both sides of the aisle. Other key issues affecting passage are the ability of President Obama to mobilize support, the perceived need for a bill and the ability to finance the reform. She said there is no bill right now so the quicker an actual bill is brought forth, the better chance it will have, pointing out that the biggest challenge is financing health care reform.

Mr. Paul Leary, Deputy Administrator, Division of Medicaid, Department of Health and Welfare, gave an update on the Children's Health Insurance Program (CHIP) B and Access Card programs. Materials provided by **Mr. Leary** to the Task Force are available in the Legislative Services Office. **Ms. Robin Pewtress**, CHIP Director, Division of Medicaid, Department of Health and Welfare, spoke on the Children Health Insurance Program Reauthorization Act (CHIPRA) of 2009 with regard to outreach and enrollment, premium assistance, quality and expansion.

Mr. Laren Walker, High Risk Reinsurance Pool Administrator, gave a presentation entitled "Idaho Individual High Risk Reinsurance Pool, Monthly Operations Report, June 2009," available in the Legislative Services Office. Also introduced was **Mr. Hyatt Erstad,** Chairman of the Board, Individual High Risk Reinsurance Pool Board. He said the High Risk Pool is designed to provide health insurance coverage for those who are rated too high by the insurance company causing coverage to be not affordable. The Pool has a number of different plans that insurance companies operating in Idaho are obligated to offer to individuals who are denied coverage or are rated too high. This program is funded first by an insurance premium, investment revenues, premium tax dollars and federal grant dollars. **Mr. Walker** said that total assets for 2009 as of June 30, 2009 were $18,606,198 with liabilities of $22,030,849 resulting in a deficit of $-3,424,651.

Representative Rusche commented that the average Pool premiums are about $190 monthly per

individual. **Mr. Walker** responded that rates were all over the place based on age, choice of plan, and many categories, but that may be the average. **Representative Rusche** asked what the Pool's benefit packages look like. **Mr. Walker** said there are five different plans with varying deductibles, co-payment percentages, annual out-of-pocket maximums and prescription drug benefits. The most utilized is the Catastrophic B Plan has a lifetime maximum, $5,000 deductible, a 80/20% post deductible co-pay, $5,000 maternity benefit, an annual $500 outpatient prescription drug deductible, and $10,000 individual out-of-pocket. **Mr. Walker** shared information through July 20, 2009 on total ceded risks (total lives) at 1,440; the total unique lives enrolled since the Pool's inception is 7,157.

Representative Bilbao asked about the lifetime maximum with regard to a catastrophic illness, if the cost of treatment exceeds $1 million. **Mr. Walker** said that before a member reaches that lifetime maximum, the member is enrolled with another carrier so a new lifetime maximum can be utilized. **Representative Bilbao** asked if the second carrier could refuse and **Mr. Walker** said that the carrier cannot refuse.

Representative Rusche asked whether insurance carrier medical management programs are being applied to the High Risk Pool. **Mr. Walker** said that was a great point. Idaho is not trying the recreate the wheel. Existing insurance company programs are being utilized.

Mr. Walker handed out a flyer for the 41st Annual Management Conference "Changing Lives by Developing Great Leaders" to be help September 23-25, 2009 in Sun Valley, Idaho, a keynote presenter being **Governor Michael O. Leavitt** speaking on "What It Takes To Build a Better Health Care System."

Senator Cameron expressed his appreciation to **Mr. Walker** and the Board, stating that this Pool was promoted by this task force seven years ago and the successes and benefits of the Pool are now being realized. He said that the Legislature made a decision to reduce the premium **tax** and now that reduction is had an effect, warning that the Pool may be presently solvent but claims continue to grow and the Pool is vulnerable to big claims. There is no denial of coverage through the Pool and there is not the ability to cost shift within the Pool. **Senator Cameron** thanked the task force for their work on this Pool which is being utilized, adding that Idaho has become the envy of other states because it has a direct funded source and he thanked the Board as well. He said that with regard to health care reform, many people are denied coverage, but in Idaho there is coverage for high risk individuals if they don't qualify for normal coverage.

Mr. Walker responded that claims have grown 20% annually for the past seven years. Meanwhile the amount of premium tax dollars received by the Pool have fallen from $7.2 million in FY 2006 to $4.4 million in FY 2009. The Pool does have the ability to place an assessment on the insurance carriers as a backup funding source.

Representative Rusche asked how many people are covered under individual policies in the state of Idaho, wondering the percentage that were in the High Risk Pool. **Mr. Erstad** responded that it would vary between Blue Cross and BlueShield, and he guessed that it would be 2 to 4%. Although reserves are solid currently, **Mr Erstad** reassured the task force that this Pool is being

closely monitored.

Senator Stegner announced that the Mental Health Subcommittee would meet on August 27, 2009, at 8:00 a.m.

The next meeting Health Care Task Force meeting will be held on September 28th, 2009 at 10:00 a.m. and the Subcommittee on Immunizations will be held also on September 28, 2009, at 8:30 a.m. in the Supreme Court basement conference room at 451 W. State St., Boise, Idaho.

The meeting was adjourned at 3:25 p.m.